# CURRENT PROBLEMS OF SOME NEW YORK CITY HEALTH AGENCIES*

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NEW YORK CITY has a number of public agencies which deal with health, including the New York City Health and Hospitals Corporation, the Department of Health, the Department of Mental Health, Mental Retardation and Alcoholism, the Medical Health Research Association, and the Health Systems Agency. The Office of the Chief Medical Examiner is administratively within the Department of Health and the Emergency Medical Service is a unit of the Health and Hospitals Corporation. To understand current functions of these various agencies, one must also be familiar with some basic characteristics of the populations they serve.

New York City, with a population of 7.3 million, is the largest city in the United States. Its population exceeds that of 42 of the 50 states, the city covers 300 square miles, and is divided into five boroughs. The city's multiethnic demographic composition is well known. Ethnic groups have historically played a major role in the city's political process. This role continues to this day, and extends into those political processes involved with health care delivery.

During the past two decades, and particularly during the past several years, major demographic changes have occurred in the city that have had a major impact on the city's health care delivery system in a variety of ways. In essence, the past two decades have witnessed the steady departure of white middle class populations and their replacement by poor Black and Hispanic groups, both from other areas of the United States and from other countries.

It is difficult precisely to quantify the magnitude of demographic

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changes since the 1970 census. Consensus holds, however, that the middle class white population will decline to 50% or even less by 1980.

These unprecedented demographic changes are the dominant fact with regard to health-care delivery. Many hospitals have found themselves in changed neighborhoods, separated from their former constituencies, abandoned by their medical staffs, and unable to raise philanthropic funds. Even hospitals for whom caring for the poor was a tradition have been overwhelmed by the problem.[1] To a large extent, the care of the working poor, those not on public assistance but too poor to pay their hospital bills, has become a responsibility of the municipal hospital system. Care of the indigent who are on welfare comes from tax levy funds. Almost a million people are now on welfare in New York City.

New York City has historically provided high levels of health care to its citizens, primarily through its municipal hospitals and Department of Health clinics. During the past several years, the city's abilities to continue these levels of services have been greatly compromised by its steadily shrinking tax base. The city's continuing fiscal crisis since 1974 has had an enormous impact on the current structure and functions of city agencies responsible for health. The form and function of these agencies will undergo major alterations as the fiscal crisis continues.

Simultaneously, two other factors are shaping the future in this regard. The state of New York has gradually assumed a number of the standard-setting and regulatory functions once performed by city agencies, particularly those of the Department of Health. This process has been going on for well over a decade, but has appreciably accelerated during recent years because of the state's desire to absorb these functions. The continuing fiscal crisis has greatly weakened the city's heretofore strong resolve to retain them, a factor sure to hasten the process.

In the hospital sphere, the Health and Hospitals Corporation's multiple problems are compounded by all the difficulties surrounding hospitals in New York City. Processes leading even to partial resolution of these difficulties will have an appreciable impact on the corporation's institutions.

This presentation cannot review all of the facets of New York City's extremely large and complex health care delivery system but will focus on two of the city's public agencies: the Department of Health and its related Medical and Health Research Association and the New York City Health and Hospitals Corporation (HHC).

## Historical Perspective

To set the stage, it is useful briefly to review recent historical developments. During the 1960s, two major administrative measures resulted in sweeping changes in the form of the city's health agencies. First was establishment of the Health Services Administration, one of several superagencies set up by the Lindsay administration to pull together the city's supposedly inefficient, uncoordinated, and duplicative health activities. Agencies which were brought under the Health Services Administration were the Department of Health, the then Department of Community Mental Health Services, the Office of the Chief Medical Examiner, and the Addiction Services Administration.

Second was the enactment of the New York City Health and Hospitals Corporation Act by the state legislature on May 26, 1969. This act created a public benefit corporation to administer the city's municipal hospitals and in effect abolished the old Department of Hospitals, whose head reported directly to the mayor. The establishment of HHC was generated by years of dissatisfaction with the functioning of the Department of Hospitals and by a number of state and local government study commission reports which advocated a change in governance as a major solution to the problems of the municipal hospitals.

The Board of Directors of HHC consists of 16 members. Five of these are ex officio and include the Health Services Administrator, who is *de jure* chairman of the Board, the Commissioner of Health, the Commissioner of Mental Health, Mental Retardation, and Alcoholism, the Human Resources Administrator, and a Deputy Mayor. Five other members are appointed by the mayor and five by him with the approval of the city council. The 16th member is the corporation president, chosen by the rest of the board.

Although on the surface it appears that the mayor has rather firm control of the corporation through its appointed board, this has not been the case. Members appointed by one mayor have not always cooperated with subsequent ones. Those appointed with City Council approval have often in effect been City Council agents independent of the mayor. Some board members have specific political constituencies, whose wants and needs the members support in both rhetoric and voting action, even when this runs counter to the collective wisdom, the wishes of the city's administration, or both. The board's eight-year history clearly shows that mayoral control

of the board is present more by chance than by predictable design.

In 1974, when Abraham Beame became mayor, he took steps to dismantle the Health Services Administration, an action which legally required City Council approval. The reasons for this decision lay in the disappointing performance of the superagency, which did not achieve what was intended of it but which did constitute an extremely expensive layer of bureaucracy. With this intent, Mayor Beame appointed Dr. Lowell E. Bellin both Commissioner of Health and Acting Health Services Administrator. The latter designation had a twofold purpose: to enable Dr. Bellin to dismantle the superagency and to fill the position of chairman of the HHC board. Although the Health Services Administration (HSA) was not legally abolished until 1977 by an act of the City Council, it ceased to be a reality six months after Dr. Bellin assumed office. His stated intent to abolish HSA resulted in the desired resignation of the heavy layer of executives and managers of which the agency was primarily composed and tax-levy savings of close to two million dollars.

Dissolution of the HSA posed a difficult legal problem with regard to the HHC board. The HHC Act of 1969 specifically legislated the HSA administrator as chairman. Can there be an HSA Administrator without an HSA? This question arose on a number of occasions during 1976 and 1977. The legal opinion was that there could be such a position, and meant that the HHC Act would not have to be amended to provide a new chairman of the board or a process for selecting one. Therefore, both the Beame and Koch Administrations have designated acting Health Services Administrators for the sole purpose of chairing the HHC board. During the Beame administration the position was filled by the Commissioner of Health, which in effect gave the commissioner two votes on the board. The Koch Administration has not followed this model. Initially in 1978, the Deputy Mayor for Finance was appointed acting Health Services Administrator to make him chairman of the HHC board. Then a full-time acting HSA Administrator other than the Commissioner of Health was appointed and given executive powers as chairman of the board. This created a situation without precedent in the corporation. Several months after being in office, the individual holding this position resigned. The mayor then appointed the Deputy Mayor for Finance as acting HSA Administrator, and he now serves as chairman of the HHC board. Changes in this arrangement may occur in the future.

During the Beame Administration the Comprehensive Health Services

Agency was replaced by the Health Systems Agency, a federally funded body whose function is health planning. To maintain city input into this agency, the bylaws were written so that the Commissioner of Health would serve as either chairman of the executive committee or as chairman of the board. In view of the city's diverse health-care activities and its yearly expenditure of 1.6 billion dollars on health, this was seen as an important linkage.

The practical form that emerged had the Commissioner of Health serve simultaneously as acting Health Services Administrator, chairman of the board of HHC, chairman of the Executive Committee of the Health Systems Agency, and chairman of the Inter-Agency Health Council composed of all city agencies involved in health matters. The Commissioner of Health also served as the mayor's principal health advisor.

All of this changed during the Koch Administration. The Commissioner of Health, although still a member of the HHC board, is no longer acting Health Services Administrator and Chairman of the Board. The mayor, in addition to appointing another individual to these seats, has also appointed a "dollar-a-year" special health advisor.

During the early months of the Koch Administration the Health Systems Agency moved to change its bylaws and oust the Commissioner of Health from the *de jure* right to be either Chairman of the Executive Committee or Chairman of the Board. Groups within both the staff and the board of the Health Systems Agency had always been uncomfortable with this arrangement because it held the potential for significant city control of the agency.

Influencing this change in the bylaws was the situation affecting the executive director of the agency, who was voted into office by the board from an acting position over the objections of the city administration. The objections did not relate to the qualifications of the executive director, but because the board was appointing him without going through the search process required in the agency's federally approved bylaws. The Koch administration unsuccessfully attempted to recommend a search process through its city representatives on the board of the Health Systems Agency. Shortly thereafter, the board changed its bylaws to enable it and the executive committee to elect their own chairpersons. By so doing, the agency's board perceives that it has divested itself of city control and achieved the status of a free standing independent agency.

This present situation represents but a temporary point in the life of a

rapidly changing scene which a year from now may bear little resemblance to what is present today. The kaleidoscopic shifts in loci of governance and the almost annual turnover of key executive personnel in this complex system should cause serious reflection and warn that present processes cannot solve our ever-mounting health care problems. This is not to say these problems are insoluble, but that they are only so in face of processes whose age have conferred permanency, reverence, and impotence.

## The New York City Health Budget

The city's current expense budget is 14 billion dollars. Of this amount, 1.4 billion is allocated for health services. Included in this are 1.2 billion dollars for the HHC, 75 million dollars for the Department of Health, and the remainder for the activities of what was once the Addiction Services Agency (ASA) and the Department of Mental Health, Mental Retardation and Alcoholism. The ASA was folded into the Department of Health in 1977 when the Health Services Administration was legally abolished. More recently, in 1978, the drug-free programs, which represent most of the monies once present in the ASA budget, have been taken over by the State of New York. Of the 75 million dollars in the Health Department budget, only 32 million are tax-levy monies. The remainder are federal government grants. It is abundantly clear that most health dollars go to the HHC. It and the Department of Health are agencies involved in direct services. The Department of Mental Health, Mental Retardation and Alcoholism is primarily a funding agency.

## Department of Health

The Department of Health currently has a staff of about 4,000 employees and carries out a number of direct service and regulatory functions. These many functions are carried out from the central office, 13 district health centers, 56 child health stations, and more than 1,000 school health clinics. Among the services are maternal and child-health clinics providing a broad range of preventive, educative, and referral services, school health clinics, sexually transmitted disease clinics, and tuberculosis clinics. Maternity and family-planning services and services for handicapped children are provided in addition to service at eye clinics and tropical disease clinics. The department operates a large dental health program with 11 district clinics and 123 school clinics.

The department's Bureau of Preventable Diseases is responsible for

the investigation and control of communicable diseases and until recently administered the immunization program. The latter has now been shifted to another locus within the department.

Other traditional public health functions include public health nursing, nutrition, social work, public health education, laboratory services, and vital statistics. The department also operates a very large methadone-maintenance treatment program, a lead-poisoning control program, and environmental health services which cover a spectrum of areas. Included among these are restaurant inspection, pest control, radiation control, public health engineering, and animal affairs. The department administers the prison health and mental health services and an employee-counseling service for all city employees for detection and treatment of emotional disorders in city workers to improve their productivity. It has been an innovative and highly successful program.

The Chief Medical Examiner reports directly to the Commissioner of Health on administrative matters but is professionally autonomous.

The five-member Board of Health is a quasilegislative body which meets monthly to consider changes, additions, or deletions in the Health Code and other matters related to the code. It is chaired by the Commissioner of Health.

In November 1974 the City of New York entered a serious fiscal crisis. The Department of Health, like all city agencies, was asked to make drastic reductions in its budget, services, and personnel. To minimize the impact of the fiscal crisis on public health, the department established two levels of programmatic priorities. Life-preserving services such as communicable disease control were sheltered from the budget reductions. Lower priority, life-enhancing services such as nutrition, social work, and public health education were reduced and absorbed most of the department's cutbacks. During this retrenchment, the department's tax-levy budget was reduced by 20%, from $50 million to $40 million, and its staff by 28%, from 6,000 to 4,300. Much of the personnel loss was due to attrition from resignations and retirements. During 1975 and 1976 a hiring freeze was imposed on all city agencies so that key professional personnel could not be replaced when they resigned or retired. In 1977 the hiring freeze was partially lifted, and the department was able to attract some new talent.

The specific program reductions and losses which occurred between 1974 and 1977 have been outlined previously.[5] Prior to and during the

crisis certain regulatory and inspection functions were transferred from the department to state agencies. Hospital inspection and regulatory functions were transferred to the New York State Department of Health and wholesale and retail food inspection to the State Department of Agriculture and Markets. In early 1977 the department lost its legal battle to retain the Quality Medical Assurance part of the Medicaid Program, which was taken over by the state. None of these transfers of functions emanated from the city Department of Health, but from the state government. The city department *de jure* derives its powers from the state Department of Health.

During the city's fiscal crisis of 1974-1978, the city Department of Health strongly resisted state take-over of its functions. It had a fine record of performance, and as a local agency was under closer scrutiny in this regard than is often the case with statewide agencies. The Beame administration supported continued local governance of these functions. Thus, in spite of the setbacks of the fiscal crisis, the department retained a large cadre of highly qualified professionals, and did not fall apart as some had predicted.

The Koch administration has adopted a policy of giving up as many of the Department of Health's functions as possible. The state has taken over the large drug-free program from the department this year, and has expressed a strong desire to absorb the city's vital statistics service. With regard to the latter service, the inadequacies of the state's system are widely known. In keeping with this policy position, the current leadership of the Department of Health has proposed transferring the Maternal and Child Health Program to the Health and Hospitals Corporation as well as the venereal disease, tropical disease, and tuberculosis clinics.

The immediate result of these as yet uninstituted plans has been flight of qualified professionals from the department. A number of other professionals have left because of the present city administration's inflexible residency requirement. It is doubtful that public health would best be served by transferring primarily preventive programs to already overburdened outpatient services in a hospital system which is itself on the verge of bankruptcy. From the fiscal standpoint such a transfer would result in the city's loss of 50% state public health matching funds, and in the end these services would cost the city twice what they now cost.

The more fundamental issue here is the desire of the present city administration to divest itself during these difficult fiscal times of whatever public health activities it can. Some have persuasively argued that in the

long run the city's dwindling health dollars would be better spent on preventive medicine and public health than in propping up duplicative and inefficient hospital services.

### Medical and Health Research Association

MHRA, as it is widely known, was incorporated in September 1957 as an independent, self-sustaining entity to conduct health research, program evaluations, demonstrations, and pilot studies and service programs for health-related city agencies. These funds in principle are obtained by grant or contract from the federal and state levels and from private foundations. The association is directed at present by a 20-man board of directors.

Although it oversees projects not intimately tied to the New York City Department of Health, the bulk of the association's $12.6 million budget for the past fiscal year (October 1976-September 30, 1977) consisted of federal grants given through it to the city Department of Health. During the extremely confusing days of the fiscal crisis in 1975 and 1976, spending and hiring freezes were imposed on all programs, even those funded totally by federal dollars. This policy was later rescinded, but while it was in effect the Department of Health arranged to have a number of such grants channeled through MHRA. An added advantage to this arrangement insulated the grants from the city's rather high administrative overhead charges. Most grant monies which MHRA administers are for programs operated by the city Department of Health. Among the most important of these are the Maternity, Infant Care-Family Planning Projects accounting for $4.6 million.

Although MHRA has a close operational relation with the city Department of Health and is from a certain perspective a "fiscal drop" for Health Department grants, it is administratively quite autonomous. And in recent years it has branched out into activities associated with noncity health-care providers. It is an article 28 institution, and consequently now has close ties with the state Department of Health.

### The Health And Hospitals Corporation And The Hospital War

The HHC, like its predecessor, the Department of Hospitals, has spent its life in troubled seas. Much has been written and said about the HHC by the wise and experienced. Hospital administrators, public health experts, consumer advocates, community leaders, managers, financiers, bankers, local, state, and federal politicians, patients, physicians, nurses, orderlies,

maintenance crews, and many others have all given their views about the HHC. Voluminous and expensive fiscal plans have been prepared and implemented. Yet troubles mount at an ever escalating rate with each passing year. The soothing idioms—cooperation, regionalization, merging, integration—have been spoken so long and have resulted in so little that few have faith in their ability to solve problems at this point. They have now been replaced by marketing jargon, which will have its day and will also fail.

In a philosophical sense, the fiscal problems which beset both the muncipal and nonmunicipal hospitals are present through human intent. Within these vast and complex systems are multiple, equipotent self-interest groups. For years now they have been poised and armed to defend their specific vital interests. And they have done this quite successfully, as well as the Germans and the French did in western front trenches during World War I. As in that war, the result in this New York City hospital war is the same: stalemate and slow exsanguination of all parties concerned.

In place of artillery, guns, and grenades, the participants in this hospital war employ bureaucratic maneuvers, political influence, public demonstrations, and fiscal tricks and gimmicks. The potential arbitrators, the state and city governments, have so far been largely immobilized because of fear of electoral repercussions from decisions which, if taken, would alienate large voting constituencies. This is a risk few politicians are willing to take in an era of narrow-margin electoral victories.

When armies failed to make progress in World War I, a predictable sequence of events developed. Generals were judged incompetent, lacking the ingenuity and skill to win. They were relieved of their commands and replaced by new men said to be better but who also failed like their predecessors, not because they lacked ability but simply because their presence was insufficient to alter a balanced equation.

Parades of new executives and managers have marched in and out of New York City's hospital systems during recent years with ever accelerating speed. Their departures should not be interpreted as signs of failure. They simply do not have it within their power to overcome the competing loci of adversary strength. Certainly there has been as much unevenness in the quality of such executives as there was in World War I generals. But, in the final analysis, their strengths and weaknesses will have little impact on the ultimate course of events.

The arrival of new executives on this scene is still heralded with great

hope and anticipation. There is hope that their new strategies will have an appreciable impact on what so many have tried their hand at without much luck. Their credibility runs high at first, supported by unrealistic hyperbolic interpretations of what they have done. These rosy views of the hospital scene have no sustaining power. As they fade, the new executive moves closer to the sacrificial altar where numerous scapegoats have preceded him. Perceptive executives leave at this point to preserve their personal futures.

Government agencies, in this case at the state level, strive to demonstrate to the electorate that they are doing something. New names are given to old functions; new bodies with impressive sounding titles are established, supposedly to replace older ones which didn't work. Regulatory powers and responsibilities are shifted and regrouped into new administrative forms, generating much fanfare and kinetic energy. But these exercises do not fool the *cognoscenti*. They represent merely the running back and forth of troops in a trench and not a forward advance. The uninformed, however, can be fooled by these exercises in bureaucratic gymnastics. Convincing evidence is regularly produced to support alleged victories, even while the major problems remain unresolved. That the western front remained stationary did not prevent victory parades on both sides of the trenches nor the generation of victory propaganda.

The outlook for an immediate solution to New York City's hospital problems is bleak. Reliance on existing processes will continue the present stalemate. Ultimately, this will lead to exhaustion on all sides and the collapse of some. But this will be a long, drawn-out affair, and the weak will fall first. To understand why this is so, one must look at some basic facts relevant to the hospital system.

At the present time there are 117 acute-care nonfederal hospitals in New York City, with a total of 42,715 beds, or 75% of the beds in the city. The remaining 25% are in federal hospitals, psychiatric institutions, and long-term-care hospitals. The HHC at present has 8,000 beds, or 21.3% of the total, while 25,300, or 66.6% of the beds, are in the voluntary sector. Proprietary hospitals have an aggregate of 4,200, or 11.2% of the beds.

While voluntary hospitals are associated in formalized societies, federations, and the like, they do not constitute a formal system as do the municipal hospitals. Recent years have witnessed declining occupancy rates in municipal and increasing rates in voluntary hospitals.[6] The average daily census in acute-care voluntary hospitals has steadily risen over the

past 10 years by close to 10% while that in municipal hospitals has fallen by 18%. Bellin has pointed out that those statistics reflect shifting of Medicaid and Medicare patients from the municipal to voluntary hospitals.[7] The reason for this shift is perception by the poor that voluntary hospitals provide better care.

Only about 10% of patients in New York City Hospitals reside outside the city. The number of such patients in hospitals in Manhattan is about 15%. It has been estimated that there are now close to 5,000 excess acute-care beds among the city's 42,000 or so beds. The reasons for this are complex but basically lie in the hitherto laissez-faire system of hospital development. Declining populations, demographic shifts, and medical advances which reduce the need for hospitalization have all contributed to build up excess numbers of beds. They have worked in concert in a system which placed high value on competition and led to hospital expansion as one means to achieve excellence and to overcome rivals.

A progressive decline in hospital-bed need did not lead to spontaneous attrition and closure of hospitals. Hospitals employ large numbers of people, and the municipal hospitals are often the chief employers in inner-city poverty areas. Hospital closings mean loss of jobs by people who live in areas where unemployment rates are in the 40th percentile. Professional careers, union-power bases, and community political platforms are all eroded when hospitals close. All these factors keep hospitals open, not because they are needed but because they are wanted. Among strategies evolved to insure hospital survival are unnecessary hospitalizations and excessive lengths of stay. The present reimbursement system encourages these practices, which together lead to high bed-occupancy rates.

New York City has 5.4 beds per 1,000 population compared to 4.4 per 1,000 in the rest of the United States. A study conducted by the Health and Hospital Planning Council of Southern New York demonstrated that occupancy rates for acute-care hospitals ran about 84.4% in New York City compared to 75.7% in the rest of the United States,[1] which means that there are not only too many beds in the city but that many are filled primarily by unnecessary hospitalization and excessive length of stay.

Occupancy rates in the municipal hospitals now average 78% compared to 87% for the voluntaries. Considering that these rates represent herculean efforts to fill beds and to keep them filled, one gets an idea of the magnitude of the excess bed problem.

The average daily cost of inpatient care in hospitals in New York City is 58% higher than in the rest of the country. This has been attributed to higher wages paid to hospital employees and higher overhead expenses in the city. The municipal hospitals receive a higher daily Medicaid and Blue Cross reimbursement rate than most voluntaries in the city, and both these rates are much higher than rates elsewhere in the country.[8]

Much has been said of the demands made by the city's uninsured poor on the municipal hospitals. It is roughly estimated that some 15% of HHC's annual deficit is due to caring for those who cannot pay. Most of this burden is carried by the municipal hospitals' outpatient departments where as many as 50% of patients must be cared for free because they have no coverage and cannot pay. The municipal hospitals care for most of these ambulatory patients because voluntary hospitals often refuse to treat them.

The linkage of hospital beds to jobs and careers has stood as a major obstacle in shrinking the system. Municipal hospital workers belong to District Council 37, a powerful union which now holds increased leverage in city affairs because of its heavy investment of pension funds in municipal bonds. Heretofore, dramatic reductions of municipal hospital beds seemed unlikely to emanate from state and local officials whose attempts to keep the city solvent depended on District Council 37's financial support. Interestingly, this union's large investment in the city's fiscal future has gradually led to a weakening of its advocacy powers. Therefore, it is conceivable that District Council 37 would make but token protests to municipal hospital closures if a failure to close would jeopardize its heavily invested pension funds. Whether or not this indeed happens remains to be seen.

To date, all parties have tolerated staff attrition through deaths and retirements, a slow, agonizing process that has not solved the problem. Lack of employment alternatives for hospital workers in New York City, many of whom have only recently worked their way up out of poverty, leaves them no option but to harden their position. Most will agree that there are too many hospital beds in New York City, but they also agree that these beds are not in their particular hospital.

The steady drain of this stalemate on the public tax levy has been enormous. And the quality of care, particularly in the municipal hospitals, has progressively deteriorated because viable municipal hospitals suffer attrition and reduced funding to prop up nonviable sister institutions. In

some municipal hospitals, what was once an exodus of professionals has now become a flight.

Awareness of this desperate state of affairs on the part of political leaders was absent until quite recently. It may make possible political decisions which would not have been possible previously.[9] The mayor's principal health advisor has publicly spoken of cutting the municipal hospital system to 50% of its present size.[10] Such a statement would not have been made a year ago.

Whether the increased awareness of the now desperate state of the hospital war will create an atmosphere in which heretofore unacceptable political decisions can be made is still an unanswered question. While the mayor may make decisions about the municipal hospital system, it is the governor and state agencies which have the power to shrink the voluntary system.

All parties to this struggle know what is needed. But none so far have been willing to take the bold steps required to solve the excess-bed problem expeditiously. Their continued participation in current processes will lead to a long, protracted, and exhausting struggle which will go on for several years. Such a struggle will be costly and agonizing for everyone. But in the view of some it is worth the effort because they hope to be among the winners.

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